

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

62-003609

STATE FILE NUMBER

- AMENDED

Registration District No.

FILED JAN 25 1962

Primary Registration District No.

1003

Registrar's No.

737

1. PLACE OF DEATH a. COUNTY 1 yr.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 11 mo. 10 days	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Chronic Hosp.		d. STREET ADDRESS (If outside, give location) 4398 Olive St.	
3. NAME OF DECEASED (Type or print) First John Middle COCHRAN Last		4. DATE OF DEATH Month Jan. Day 14 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH August 3, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	
13a. FATHER'S NAME John Cochran		13b. MOTHER'S MAIDEN NAME Mary ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No , or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Thelma Singler Chronic Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma of the left lung Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 162.1 DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Generalized arteriosclerosis		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 9:40 a.m. Month, Day, Year 2-4-60		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION St. Louis	
21. I attended the deceased from 2-4-60 to 1-14-62 and last saw her/him alive on 1-14-62 Death occurred at 9:40 A m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE S. E. Smith (Degree or title)	
22b. ADDRESS 5600 Arsenal		22c. DATE SIGNED 1/15/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/16/1962	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	
24. FUNERAL DIRECTOR Morrell Mortuary		25. DATE RECD. BY LOCAL REG. JAN 17 1962	
26. REGISTRAR'S SIGNATURE Carl Smith, M.D.		27. LOCATION (City, town, or county) Normandy, Mo.	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.